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10 CFR 50.73

Ref

CP-201900191 TXX-19039

U. S. Nuclear Regulatory Commission

ATTN: Document Control Desk Washington, DC 20555-0001

4/25/2019

SUBJECT:

COMANCHE PEAK NUCLEAR POWER PLANT

**DOCKET NO. 50-446** 

MANUAL REACTOR TRIP DUE TO FEEDWATER ISOLATION VALVE CLOSURE

LICENSEE EVENT REPORT 446/19-001-00

# Dear Sir or Madam:

Pursuant to 10CFR50.73, Vistra Operations Company LLC (Vistra OpCo), hereby submits the enclosed Licensee Event Report 446/19-001-00, "Manual Reactor Trip Due To Feedwater Isolation Valve Closure" for Comanche Peak Nuclear Power Plant (CPNPP) Unit 2.

This communication contains no new licensing basis commitments regarding CPNPP Unit 2.

IEZZ NRR If you have any questions regarding this submittal, please contact Gary L. Merka at (254) 897-6613.

Sincerely,

Thomas P. McCoo

Enclosure

COMANCHE PEAK NUCLEAR POWER PLANT

MANUAL REACTOR TRIP DUE TO FEEDWATER ISOLATION VALVE CLOSURE

LICENSEE EVENT REPORT 446/19-001-00

c – Scott Morris, Region IVNatreon Jordan, NRRResident Inspectors, Comanche Peak

## NRC FORM 366 (04-2017)

## U.S. NUCLEAR REGULATORY COMMISSION

PPROVED BY C	MB: NO.	3150-0104
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EXPIRES: 03/31/2020

# LICENSEE EVENT REPORT (LER)

(See Page 2 for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Information Services Branch (T-2 F43), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by e-mail to Infocollects. Resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

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NRC FORM 366A (04-2017)

U.S. NUCLEAR REGULATORY COMMISSION



# LICENSEE EVENT REPORT (LER) **CONTINUATION SHEET**

(See NUREG-1022, R.3 for instruction and guidance for completing this form http://www.nrc.gov/reading-rm/doc-collections/nuregs/staff/sr1022/r3/)

APPROVED BY OMB: NO. 3150-0104

EXPIRES: 03/31/2020

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1. FACILITY NAME		2. DOCKET NUMBER	3. LER NUMBER					
Comanche Peak Nuclear Power Plant	05000-	446	YE	EAR	SEQUENTIAL NUMBER			REV NO.
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#### NARRATIVE

### I. DESCRIPTION OF THE REPORTABLE EVENT

### A. REPORTABLE EVENT CLASSIFICATION

This event is reportable under 10CFR50.73(a)(2)(iv)(A), "Any event or condition that resulted in manual or automatic actuation of any of the systems listed in paragraph (a)(2)(iv)(B) of this section." The systems that actuated were the Unit 2 Reactor Protection System and the Unit 2 Auxiliary Feedwater System.

### B. PLANT CONDITION PRIOR TO EVENT

At 0317 on March 2, 2019, Comanche Peak Nuclear Power Plant (CPNPP) Unit 2 was in MODE 1 operating at 100% power.

C. STATUS OF STRUCTURES, SYSTEMS, OR COMPONENTS THAT WERE INOPERABLE AT THE START OF THE EVENT AND THAT CONTRIBUTED TO THE EVENT

There were no structures, systems, or components that were inoperable prior to the event which contributed to the event.

D. NARRATIVE SUMMARY OF THE EVENT, INCLUDING DATES AND APPROXIMATE TIMES

On March 2, 2019, a Reactor Operator (Utility, Licensed) was performing a weekly activity from the Shift Manager Daily Activities Log to check for buzzing relays and blown fuses in the Unit 2 Main Control Room back panels. During this activity, the Reactor Operator heard a buzzing relay and attempted to narrow down which relay was buzzing by lightly touching the relays to see if the buzzing would stop. When he touched the armature of the feedwater circuit relay, the force was enough to actuate it causing Feedwater Isolation Valve 2-04 [EIIS:(SJ)(ISV)] to close. At 0317, CPNPP Unit 2 was manually tripped due to an unexpected closure of Feedwater Isolation Valve 2-04 and loss of Steam Generator 2-04 level control [EIIS:(JB)(LC)]. All systems functioned as designed and the Unit 2 Auxiliary Feedwater Pumps started as designed due to low level in Steam Generator 2-04. There was no impact on Unit 1.

E. THE METHOD OF DISCOVERY OF EACH COMPONENT OR SYSTEM FAILURE, OR PROCEDURAL PERSONNEL **ERROR** 

Operators (Utility, Licensed) in the Unit 2 Control Room received a SG 2-04 Level Deviation Alarm on the Main Control Board.

- II. COMPONENT OR SYSTEM FAILURES
- A. CAUSE OF EACH COMPONENT OR SYSTEM FAILURE

Not applicable - There were no component or system failures during this event.

- B. FALURE MODE, MECHANISM, AND EFFECTS OF EACH FAILED COMPONENT Not applicable - No CPNPP component or system failures were Identified during this event.
- C. SYSTEMS OR SECONDARY FUNCTIONS THAT WERE AFFECTED BY FAILURE OF COMPONENTS WITH MULTIPLE FUNCTIONS

Not applicable - No CPNPP component or system failures were Identified during this event.

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### NARRATIVE

### D. FAILED COMPONENT INFORMATION

Not applicable - No CPNPP component or system failures were identified during this event.

### III. ANALYSIS OF THE EVENT

# A. SAFETY SYSTEM RESPONSES THAT OCCURRED

The Unit 2 Reactor Protection System and the Unit 2 Auxiliary Feedwater systems responded as designed.

# B. DURATION OF SAFETY SYSTEM TRAIN INOPERABILITY

This event did not involve the inoperability of any safety systems.

### C. SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

A loss of normal feedwater is an ANS Condition II event (Faults of Moderate Frequency). This event is bounded by FSAR Section 15.2, "Decrease In Heat Removal By The Secondary System." When Feedwater Isolation Valve 2-04 closed, the reactor was manually tripped and the Auxiliary Feedwater System automatically started to provide feedwater to the steam generators. The reactor trip on steam generator low level provides the necessary protection against a loss of normal feedwater.

No automatic safety functions were exercised other than the expected automatic start of the Auxiliary Feedwater System and all plant safety systems responded as designed during the resultant transient. This event had no impact on nuclear safety, reactor safety, radiological safety, environmental safety, or the safety of the public. This event has been evaluated to not meet the definition of a safety system functional failure per 10CFR50.73(a)(2)(v).

# IV, CAUSE OF THE EVENT

The cause of this event was the inadvertent bumping (touching) of a relay resulting in a close signal being sent to Feedwater Isolation Valve 2-04. The guidance provided for performing the weekly check for "buzzing" relays did not give direction to touch any components in the panel, and this was a human performance error by the Reactor Operator.

# V. CORRECTIVE ACTIONS

The Reactor Operator Involved in this event was coached, and a site stand down was conducted on the event. Activities involving relay checks were temporarily suspended, and the weekly check for "buzzing" relays was removed from the Shift Manager Daily Activities Log. Per the CPNPP Corrective Action Program, an evaluation of Operations, Control Room, and Field activities that potentially could challenge nuclear risk will be performed and all CPNPP personnel are evaluating departmental activities to determine if similar risk challenges exist that require further evaluation.

# VI. PREVIOUS SIMILAR EVENTS

There have been other manual reactor trips in the last three years. However, the causes of those events are believed to be sufficiently different from this event such that previous corrective actions could not have prevented this event.